

# CHAPTER 2:

## ASSESSMENT: HOW DO WE MONITOR THE PUBLIC'S HEALTH?

Washington State's Public Health Improvement Plan calls on local public health jurisdictions to monitor the health status of their community and the quality of their health systems. Public Health - Seattle & King County does just this, using data and other tools to identify priorities and develop policies.

Public health assessment takes a snapshot of the community's health. This involves monitoring the determinants of health (see Chapter 3 and Appendix C for more detail), risk factors, and health outcomes of a community.

Multiple factors contribute to individual as well as community health status. Assessment is carried out through analysis of the following:

- **the makeup of the community** (e.g., its demographics such as age, race, gender, and poverty rates);
- **a range of important health outcomes** (e.g., life expectancy, children hospitalized for

asthma, disease rates, births to adolescent girls, cancer deaths); and,

- **the pattern of risk factors for illness and injury** (e.g., the percent who smoke, are without health insurance, do not wear bicycle helmets, carry HIV or other chronic viral infections, are sedentary, are overweight).

The purpose of public health assessment is to monitor health trends, identify emerging problems that merit further assessment or rapid intervention, inform prioritization for limited resources, and

guide program planning and policy development. Assessment data represent the unique health status of a jurisdiction and serve as a starting point for local public

health departments and communities to identify goals for community health improvement as well as strategies for attaining those goals.

A local public health department is the primary and often the only source for comprehensive health data about their communities.

**Public health assessment takes a snapshot of the community's health.**

## HEALTH TRENDS FOR KING COUNTY

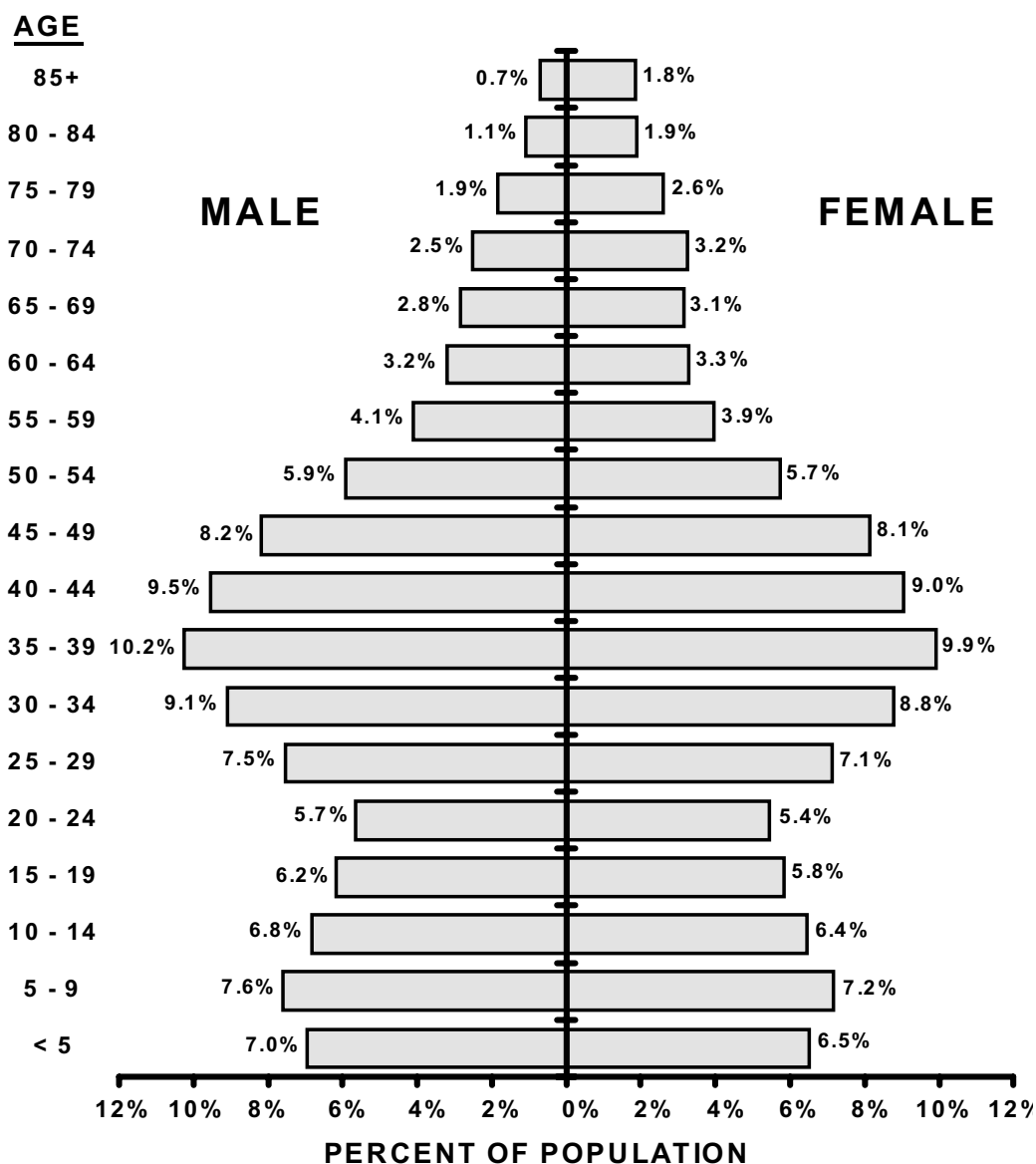
Trends in the major demographic factors and health outcomes for King County are summarized below. Two documents that best describe the health status of King County's residents and the quality

of the regional health system are *The Health of King County (1998)* and the *King County Health Action Plan (1997)*. Much of the following data have been summarized or updated from these two reports.

## DEMOGRAPHIC CONSIDERATIONS

### Total Population (See Figure I)

- The total King County population in 1996 was 1,628,801, including 534,567 in Seattle.
- Elderly people age 65 and over accounted for 11 percent of the total population.
- Children under age 15 accounted for 21 percent of the total population.



**Figure I**  
Population Distribution in King County  
By Age and Gender, 1996

**Population Growth (See Figure 2)**

- Between 1980 and 1996, the population grew 28.6 percent in King County overall and 8.5 percent in Seattle.
- The number of persons age 25-44 years surged 42.3 percent, and the number age 65 and older rose 36.9 percent. The number of youth age 15-24 years declined 19.8 percent during the same period.
- Between 1980 and 1996, the Asian population in King County tripled with a 203% increase. For other racial/ethnic groups, the increase was 120 percent for Hispanics, 76 percent for Native Americans, 65 percent for African Americans, and 19 percent for whites. Of the Health Planning Areas in King County, Southeast Seattle and Central Seattle had the largest percentages of minority population.
- It is projected that the total King County population will increase to 1,711,907 by year 2000, 1,840,172 by year 2010, and 2,030,674 by year 2020.

	Total Population	Percent	Growth Percent *
<b>King County</b>	1,628,801	100.0%	28.6%
<b>Seattle</b>	534,567	32.8%	8.5%
<b>KC Outside Seattle</b>	1,094,234	67.2%	41.4%
<b>Age:</b>			
<b>0-14</b>	337,949	20.7%	36.1%
<b>15-24</b>	188,038	11.5%	-19.8%
<b>25-44</b>	580,148	35.6%	42.3%
<b>45-64</b>	345,577	21.2%	39.8%
<b>65+</b>	177,089	10.9%	36.9%
<b>Elderly Age 85+</b>	20,890	1.3%	54.8%
<b>Race:</b>			
<b>White</b>	1,338,938	82.2%	19.3%
<b>African American</b>	91,511	5.6%	64.5%
<b>Native American</b>	21,084	1.3%	75.5%
<b>Asian</b>	177,271	10.9%	202.5%
<b>Hispanic Ethnicity</b>	58,570	3.6%	120.3%

**Figure 2**  
Population Growth in King County, 1996

## Socio-economic Factors

- According to the 1990 Census, 8 percent of all King County residents lived below the federal poverty level. The poverty rate was 6 percent among whites, 15 percent among Hispanics, 15 percent among Asians, 22 percent among African Americans, and 26 percent among Native Americans.

**Clearly, the aging of King County's population will require increased attention on prevention of chronic disease illness.**

- In 1990, among family households with children under age 18 years in King County, 22.3 percent were single parent households.
- Among King County adult residents age 25 years and older in 1990, 11.8 percent did not have a high school diploma.

continuing the trend of increased average longevity which has been a characteristic of population change in the U.S. for decades. This pattern has resulted in increasing rates of chronic disease such as heart disease, cancer, and stroke, as well as unintentional injuries, all of which are among the County's five leading causes of death.

Clearly, the aging of King County's population will require increased

attention on prevention of chronic disease. Prevention of chronic disease through individual behavior change and community-based programs are crucial to future gains in death rate reduction and life expectancy.

The increasing proportion of elderly people in King County will also place increasing demands on public health and health care systems. Older adults are more likely to suffer from multiple chronic diseases and, therefore, require more complex drug treatments and treatment regimens. In addition to increases in the current elderly population, the oldest of the "baby boom" cohort are now in their fifties, presaging further increases among this potentially vulnerable group.

## Demographic Trends:

### Implications for the Future

**Where growth is occurring:** Growth is occurring in all parts of King County; however, the rate is twice as fast outside of the City of Seattle compared to inside Seattle's city limits. Even though updated Census data will not be available until after the year 2000 Census, local school district data suggest an increase in diversity, particularly in South King County.

While, according to most measures, the need in Central and Southeast Seattle is still the highest, the growth in other areas, particularly in South King County, indicates the importance of monitoring access to care through targeted local assessment.

**Aging of the Population:** People aged 65 years and older are among the most rapidly growing segments of the King County population,

**While race is commonly employed as a marker for health status in statistical analysis, the underlying factors contributing to these health disparities are largely poverty, low education level, and discrimination.**

**Changing Racial/Ethnic Composition:** King County is becoming an increasingly diverse and multi-ethnic region, with a significant growth in Asian, Native American, Latino, and African American communities as well as White non-English speaking populations (e.g., Russians, Ukrainians, and Bosnians). The increasing complexity of our regional population and the growing numbers of individuals representing diverse backgrounds offer a richness of resources. At the same time, it raises distinct challenges for Public Health, including identification and implementation of acceptable

approaches to work with these communities across cultural and language barriers.

As summarized below, large health disparities exist for certain racial/ethnic groups. For example, African American and American Indian/Alaska Natives are particularly likely to experience

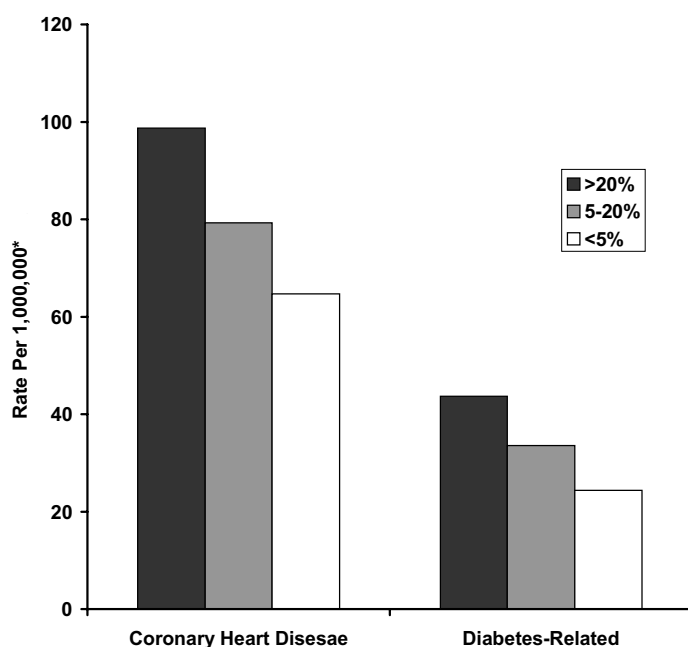
disproportionate morbidity and mortality. While race is commonly employed as a marker for health status in statistical analysis, the underlying factors contributing to these health disparities are largely poverty, low education level, and discrimination.

## HEALTH STATUS OF KING COUNTY

*The Health of King County*, published in August 1998, outlines the major health status challenges facing King County for the next several years. As noted above, a major continuing challenge is inequity in health status among diverse segments of King County's population. Health status variations, particularly those associated with neighborhood poverty level, residential community, and race/ethnicity are both long-standing and disturbing.

The following section summarizes the key health status findings presented in *The Health of King County*.

**I) Inequities in health status related to poverty.** Although the gap between high and low poverty neighborhoods in total mortality has narrowed since the late 1980s, health status continues to be significantly associated with neighborhood poverty level. For example, the death rates from coronary heart disease and diabetes-related illness (see Figure 3) continue to be higher in high poverty areas. Other conditions related to neighborhood poverty level include, infant mortality, homicide, hospitalization for mental health conditions, and new cases of sexually transmitted diseases (data not shown).



**Figure 3**  
Coronary Heart Disease and  
Diabetes-Related Death Rates\*  
By Percent Below Poverty Level^, ^,  
Five Year Average, King County,  
1992-1996

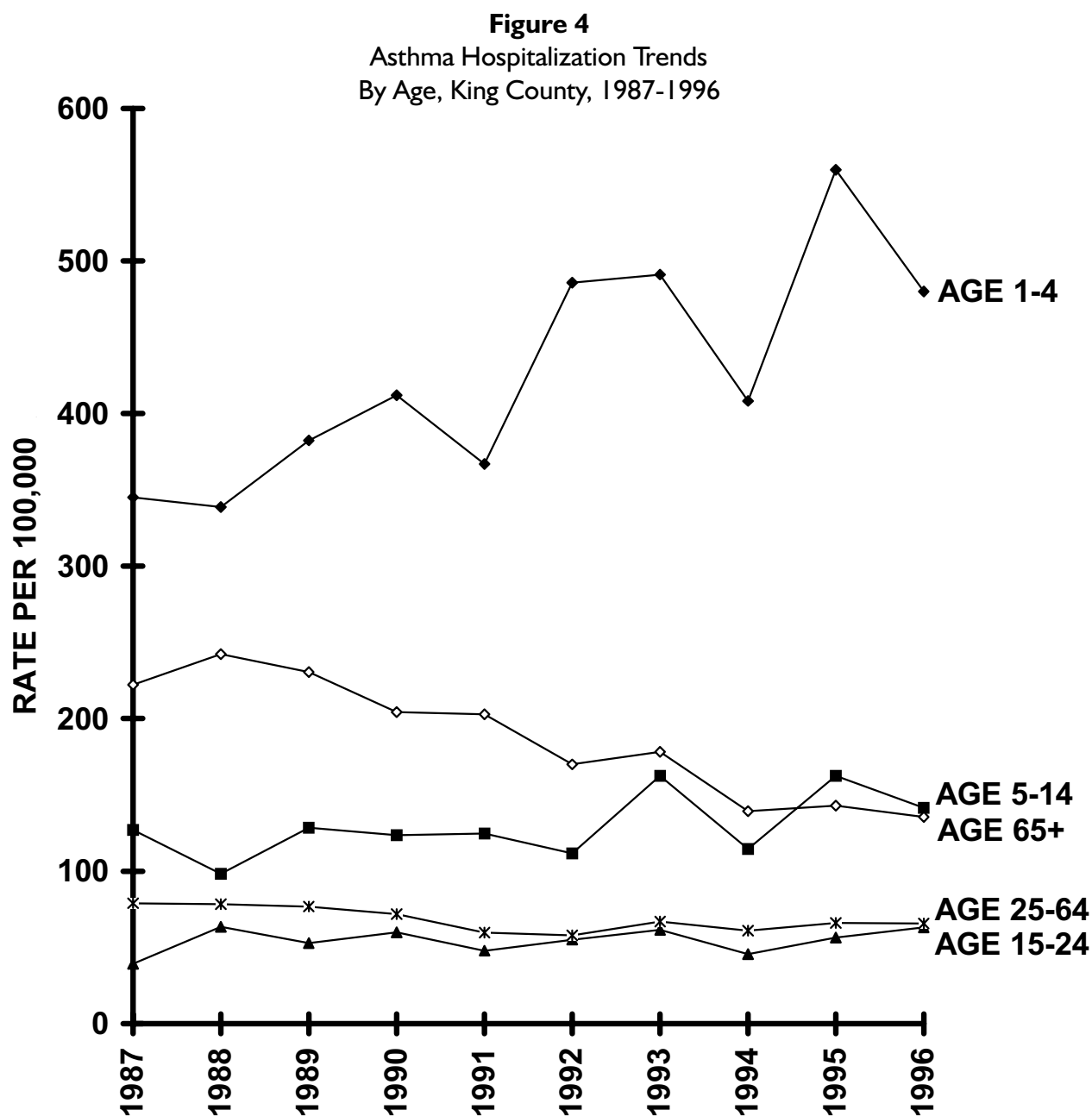
\* Rates are age-adjusted to the 1940 U.S. Population Standard.

^ Percent living below Federal Poverty Level in census tract of residence.

Note: All poverty-level-based comparisons with a disease category are statistically significantly different.

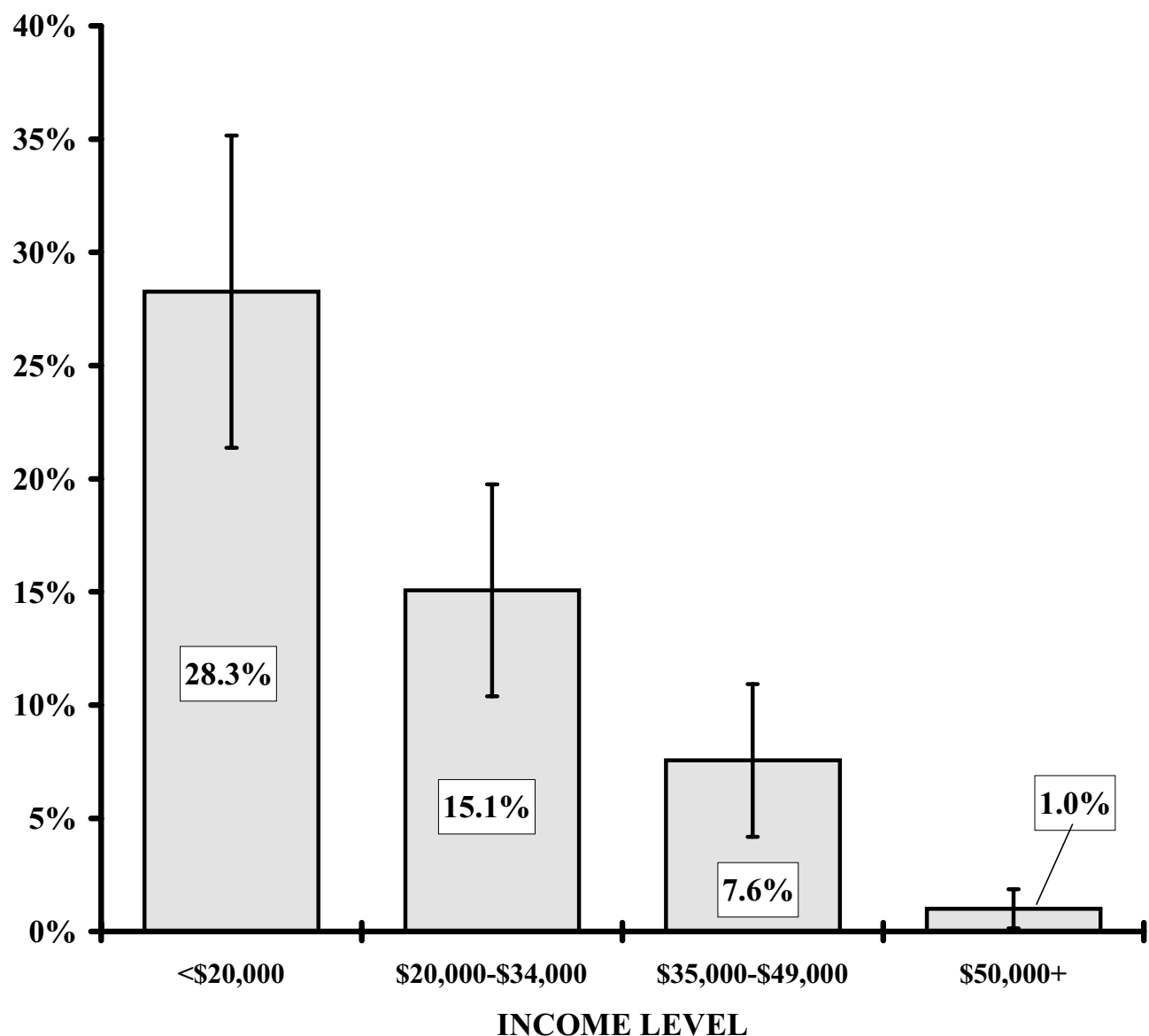
**2) Prevalence of overweight and physically inactive adults.** The prevalence of overweight status among King County adults increased from 42% in 1990 to 48% in 1996, mainly due to an increase in the “very overweight” (obese) category. In 1996, 42% of King County adults reported little or no leisure-time physical activity.

**3) High hospitalization rates for childhood asthma.** The asthma hospitalization rate increased significantly from 1987 to 1997 among children aged 1-4 and 5-14 years. For children aged 1-14 years, the rate increased by 22% during this time period. Asthma is now the leading cause of hospitalization among children, and hospitalization rates are highest among children living in low-income neighborhoods (see Figure 4).

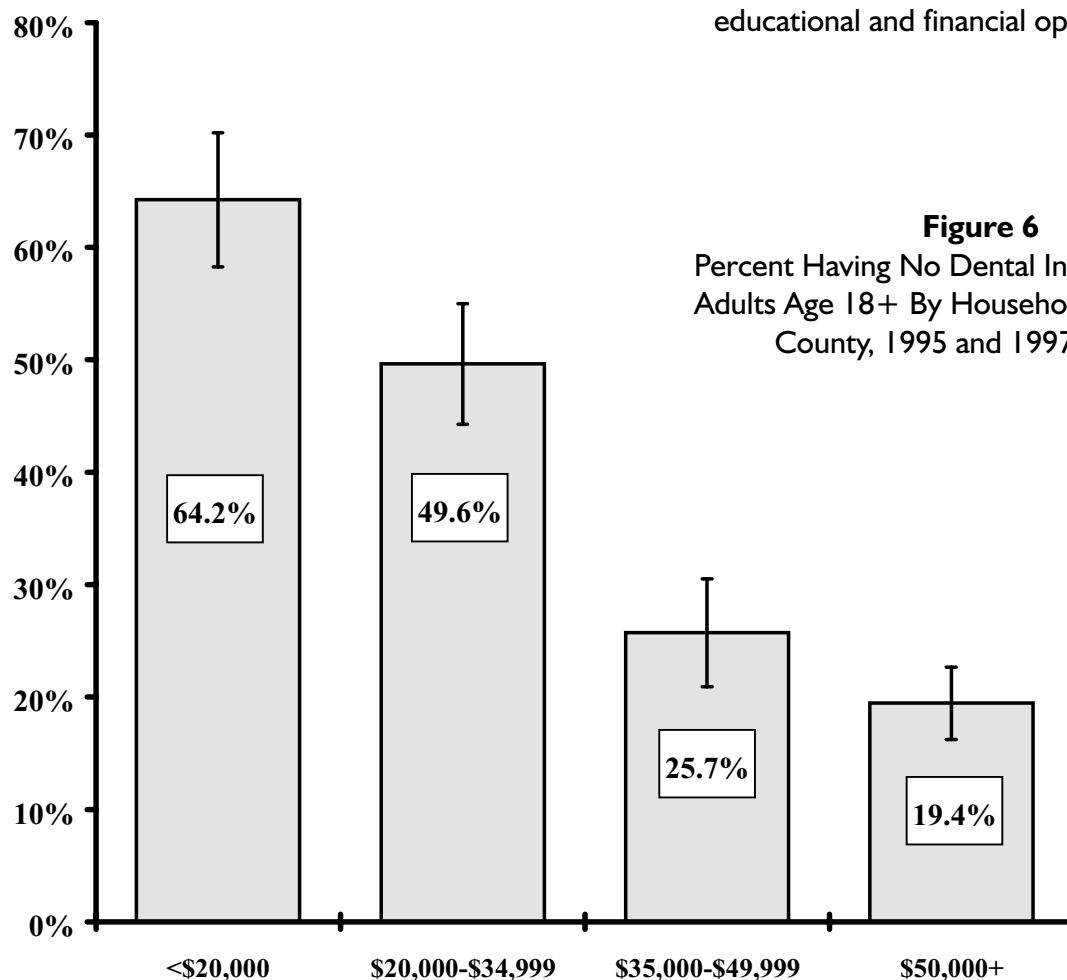


- 4) **Lack of health insurance/medical care for many residents.** One in ten King County adults age 18 to 64 years did not have health insurance in 1996, and 17% reported not having a usual place to go to receive medical care. Since 1991 and despite growth in the economy, there has not been any improvement in the percentage of insured adults in King County. Inequities in coverage continue to exist, particularly for low income households. Unmet health care needs due to cost are common among King County residents and occur in the majority of those who are uninsured (see Figure 5).

**Figure 5**  
Percent Without Health Insurance Among Adults Age 18-64  
By Annual Household Income, King County, 1996



- 5) **Lack of dental coverage** is more frequent than lack of coverage for medical care, and such coverage, where it exists, is more likely to entail high deductibles and exclusions. Almost three-quarters (73%) of those aged 65 years and older lacked dental coverage (see Figure 6) which is in stark contrast to medical insurance coverage for this group. While Medicare covers medical need, it does not cover dental need. One in three (33%) of those who did not get care in the last year gave cost as the reason .
- 6) **High death rates from accidental poisoning/illicit drug use.** The death rate from accidental poisoning - most of which was illicit drug overdose - rose three-fold between 1991 and 1996. Three-quarters of these deaths were among males age 25-54 years. The rate of death from accidental poisoning in King County was more than twice the national rate.
- 7) **High rates of unintended pregnancies.** Approximately 35% of all births to King County mothers were a result of unintended pregnancies. Studies show that women who give birth from an unintended pregnancy have an increased risk of alcohol, tobacco, and other substance-use during pregnancy. They also have increased rates of intimate partner violence, maternal depression, divorce or separation from their partner, and lose of educational and financial opportunities.



**Figure 6**  
Percent Having No Dental Insurance Among  
Adults Age 18+ By Household Income, King  
County, 1995 and 1997 Average



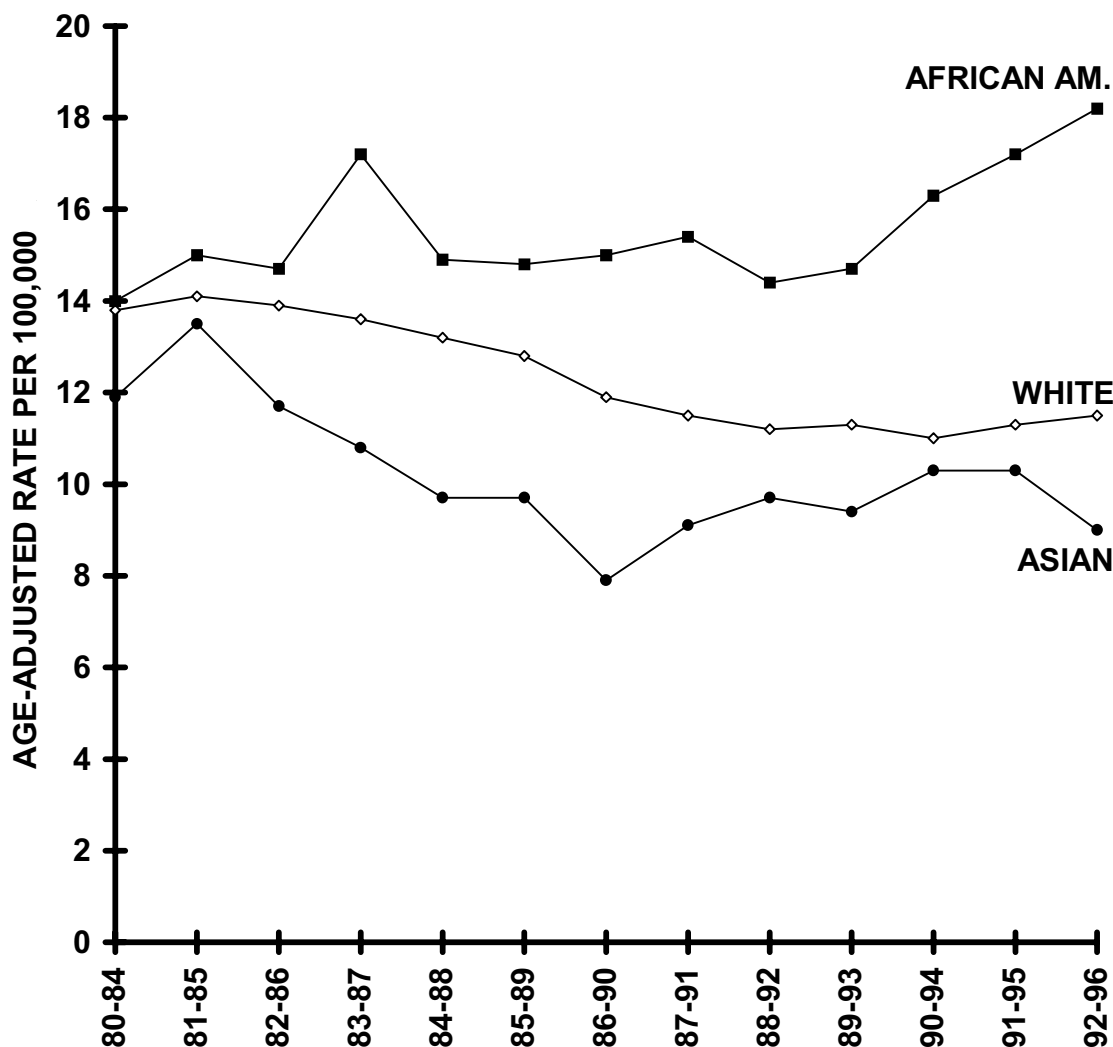
**8) Inequities in colorectal cancer death rate and low colorectal cancer screening.**

About three in four King County residents over 50 years of age did not receive appropriate colorectal cancer screening. For colorectal cancer, the age-adjusted death rate for African Americans was significantly higher than the rate for whites. In addition, the African American rate has increased significantly since 1988 (see Figure 7).

**9) High suicide rates.** The suicide rate in King County remains significantly higher than the national average. Rates are especially high among all males age 20-34 years and white males age 65 years and older.

**10) Increasing death rate for diabetes.** The death rate for diabetes has increased significantly since the mid-1980s among all ethnic/racial groups, and the increase was greatest among African Americans.

**Figure 7**  
Colorectal Cancer, Age-Adjusted Death Rates  
By Race/Ethnicity, King County  
Five Year Rolling Average, 1980-1996



## THE IMPORTANCE OF PREVENTION

Prevention of disease and promotion of good health are key strategies to reverse negative health trends and address the persistent social inequities in health. At least 50% of all deaths are associated with preventable factors. These factors include cigarette smoking, poor nutrition, physical inactivity, alcohol, microbial agents (such as bacteria and viruses), toxic agents, firearms, motor vehicles, sexual behavior, and illicit use of drugs.

The prevalence of these factors among King County residents continues at relatively high levels, and their effects on health status are substantial. For example, in 1996, 2,228 deaths (or 19% of the total deaths) in King County were caused by cigarette smoking. Nonetheless, 20% of the King County adults continue to smoke, and the smoking rate among youth has recently increased.

To decrease the occurrence of these factors, the combined efforts of Public Health, other health care providers, social service agencies, and community organizations are required. Together, we must encourage social and physical environments which promote health and encourage individuals to practice healthy behaviors, and we must assure that all residents have access to the knowledge and services that they need to treat and prevent illness.

Ultimately, innovative service delivery programs, new school and workplace policies, legislation, and community mobilization for all King County residents and especially for high-risk populations will help us consolidate our gains and make further progress towards the goal of healthy lives for everyone living in King County.

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